Alcohol Matrix cell A4: Interventions; Psychosocial therapies

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S Single session equals extended treatment (1977). For couples at a London alcohol treatment clinic a single 'It's up to you' session led to no worse drinking outcomes than the usual extended treatment of the time. See "The alcohol clinic" on p. 1 of linked PDF file.

S Confrontation provokes resistance (1993). Among US heavy drinkers motivational interviewing's non-confrontational style reduced both resistance and drinking compared to an explicitly challenging approach; click the 'alternative source' link in the Findings analysis for a free copy of the original article. See also this review of the positive role of subtle forms of 'confrontation' in motivational interviewing.

S Client-centred group therapy works best (1957). Well-controlled study found a Rogerian client-centred approach beneficially changed self-perceptions of alcoholic patients and reduced relapse compared to learning theory or analytic approaches.

K UK trial finds therapies equivalent (2008). Results of largest UK alcohol treatment trial confounded expectations that a motivational approach would best suit unmotivated or hostile clients, and that clients lacking social supports would do best when this was explicitly addressed. Overall, too, neither therapy significantly bettered the other.

K Project MATCH confounds expectations (1999). Landmark US trial designed as a definitive test of matching different types of clients to different therapies instead confirmed the importance of the 'common factors' underlying seemingly distinct approaches; for more see book (2002) of the project.

K In relapse prevention, practice makes (more) perfect (1997 and 2000). Practising relapse prevention skills rather than just discussing them boosted confidence and helped newly detoxified Scottish patients stay sober longer.

R All bona fide 'talking therapies' work equally well (2008). After combining results from relevant alcohol studies, this ingenious analysis found any structured approach grounded in an explicit model as good as any other. We have, it was argued, been looking in the wrong direction for therapy's active ingredients. See these reviews for similar verdicts on motivational interviewing (Cochrane review, 2011) and cognitive-behavioural therapy (2009).

R Common relationship factors (American Psychological Association, 2011). Introduces reviews based on the understanding that treatment methods are not simply technical interventions, but ways client and therapist relate, so cannot be divorced from the general relationship between client and therapist. From here you can find the component reviews and the overall conclusions reached by the task force.

R Motivational starts to treatment (2005). Findings review discovers that manualised motivational interviewing is not always a positive alternative to more directive approaches.

R Peer-based addiction recovery (2009). Includes chapter on the evidence for AA and allied mutual support networks and treatments based on the same principles and networks. See also this review (2004) of how treatment services can promote mutual aid and this synthesis of studies (1999) of AA-based versus other approaches.

R Some patients get *worse* (2005). Salutary reminder that after psychosocial therapy up to 15% of clients end up worse than before; some of the reasons are to do with poor therapy including a weak relationship, failing to assess how clients are doing, being confrontational or critical, low or inappropriate expectations, and lack of challenge.

R If patient is in suitable couple, work with both (2011). Problem drinkers in a stable relationship do better when the focus is at least partly shifted to working with the couple to foster sobriety-encouraging interactions.

G NICE guidance on treating problem drinking (NICE, 2011). Britain's official health advisory body recommends overall principles and particular interventions.

G Treatment principles (2006). Based on reviews commissioned by the American Psychological Association; reviews evidence and offers guidance on how to relate to clients and what to do.

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Matrix Bite a commentary on this cell from the cell-by-cell Matrix Bites course

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What is this cell about? Every treatment involves direct or indirect human interaction, but this row is about therapies in which interaction is *intended* to be the main active ingredient. Colloquially referred to as 'talking therapies', these are more formally categorised as 'psychosocial', because one dimension is about changing how the patient reacts (for example to stress) or their beliefs and attitudes, while another is to do with social influence exerted by the therapist or others such as family and employers. Interventions range from brief advice and counselling to extended therapies based on psychological theories, and all-embracing residential communities where clients stay for several months. Elements could include imposing rewards and punishments contingent on client behaviour (contingency management), leading the client to see their substance use as contrary to desired self-images or objectives (as in motivational interviewing), harnessing social influences (as in group and family therapies and community living arrangements), teaching the client what triggers their undesired substance use and how to manage or avoid those triggers (as in cognitive-behavioural therapies), and more practical elements such as vocational rehabilitation. Whether based on research and theory, religion, morals or experience, belief systems to guide the thinking and behaviour of both therapist and patient underlie these approaches; most prominent in the research are the 12 steps of Alcoholics Anonymous, and the understanding that addiction can be learnt and unlearnt on which major psychological therapies are based.

Where should I start? This cell is partly about the relative merits of different therapies, but also about the therapeutic properties they share and how such 'common factors' can be reinforced. Since these have become seen as the major influences, let's start there, and in particular with the shift to focus on these factors made by the American Psychological Association (APA). Updating work from 1999, in 2011 their task force analysed the literature to identify what constitutes an effective relationship between therapist and patient. Take a look at the introductory article which lists all the component reviews, at whichever of these reviews most interests you, and at the overall conclusions reached by the task force. Then go back a few years to the guidance offered by another APA task force which integrated these relationship issues with the content of therapy. In both note the stress on collaborative working, and warnings against being confrontational, hostile, pejorative, critical, rejecting, or blaming. However, as they also observed, on issues like this, there are no universal rules – treatment is the treatment of an *individual*.

Highlighted study For Britain it has to be the £1.5 million UKATT trial, the most ambitious ever in the UK. Implemented in the late '90s, it was informed by emerging findings from the similar US Project MATCH trial, which found a relatively brief therapy based on motivational interviewing as effective as longer therapies. In response, the UKATT team set out to devise a research-based therapy which would better this standard. They came up with 'social behaviour and network therapy'. It integrated elements from other approaches geared to harnessing the "crucial contribution" of social networks supportive of positive change. A scheduled eight sessions of this more extensive, intensive and comprehensive therapy were compared with three of the basic motivational approach. There were no significant differences in overall effectiveness or cost-effectiveness. Neither did (as had been expected) motivational interviewing particularly help angry patients or those lacking motivation, or the network option particularly help patients lacking social supports to drink less. Their expectations confounded, the researchers fell back on the equivalence of training and support offered to the therapists and of their

expectations that the approach they had been trained in would yield good results; optimism, morale, structure, support, guidance – common factors rather than the distinctions in approach and content which it was thought would prove critical. What do you take from this? Were both treatments equally effective, equally ineffective, were the researchers wrong about what is "crucial" to treatment success, or was it that these social supports *are* crucial, but such treatments – drops in the ocean of the patient's life – cannot manufacture them? Look back at the bite for cell A2 where Project MATCH was the highlighted study and we discussed the implications of such findings.

Issues to think about

▸ Can therapists really make things *worse*? Look back at **Where should I start?** and the warnings from the American Psychological Association against counsellors being confrontational or negative. Lest you think these overstated, note that they are among the reasons why a substantial minority of clients actually get worse after therapy. Avoiding this risk (especially provoking resistance to change) has been embodied most explicitly in motivational interviewing, a strategy seemingly confirmed in a seminal trial. Proofed against counterproductive reactions, appropriate for all levels of severity, generally as effective as other therapies but considerably briefer, motivational interviewing has been seen as a promising standard starting point for substance misuse therapies, which at least is unlikely (recalling the first maxim of medicine) to do any harm. That may be true in the absolute sense, but not in terms of lost opportunities to help patients who would have benefited more from another approach. Sometimes it really is best just to tell patients what they should do or otherwise break motivational interviewing's 'rules' rather than inflexibly follow the manual. The perhaps uncomfortable truth for therapists seems to be that beyond the obvious, there are no universal rules: some people need to be led, others to lead; some told what to do, others to feel they have come to their own decisions; some need arousing, others soothing – and needs can change as therapy progresses. So when with all the authority of Britain's official health standards agency, NICE advises that substance use therapy "should be based on a relevant evidence-based treatment manual", remember they mean *based*, not prescribed in advance no matter who the patient or whatever their needs.

▸ Research has to package, therapy does not. That last comment brings us to a more general point about basing interventions on research. Researchers feel they have to know exactly what is being delivered in order to identify what caused any improvements, so they manualise interventions and train and supervise therapists to make sure they follow the manual – as we have seen, not necessarily the best to do therapy. Similarly, researchers have to package their interventions in order to standardise them, limit costs, equalise time spent with therapists in a comparison therapy, and have a set end date from which the follow-up period can begin. Twelve weeks is the commonest compromise between a manageable research intervention and one which lasts long enough to possibly have the desired impacts. As a result, 12-week treatments have collected an evidence base around them, reflected in NICE's recommendations. Yet there is no reason to believe that because 12 weeks is convenient for researchers, it is also how patients should be treated. Some manage well with much less, others (see cell D2 bite) will benefit more from longer term care. Research takes its ideas from practice, standardises and packages that practice, tests it, then practitioners from whom the approach started may be persuaded this how they should do it, via recommendations from authorities who only have the research to go on. Treat research as an aid to reflection on practice, not a blueprint.

▸ Are these the important things to do? Retrieve this guidance from an American Psychological Association task force. Skip to the heading "Treatment factors" on page three of the PDF file. There you will read that research "suggests that a number of specific therapeutic elements are characteristic of effective treatments". Take a critical look at these suggestions. The list includes "explicitly helping the client restructure his or her social environment in ways that support change"; how well did that work in our **Highlighted study**, the British UKATT trial? Next up is a "focus on client motivation for change", including exercises that get the patient to weigh up the pros and cons of changing their substance use. But if (as many will be) patients are *already* committed to change, maybe it is not such a good idea to encourage them to rehearse the good things about their substance use? On this issue see study 19 in this Findings review. Go through the remaining three suggestions and check them against the research and your experiences. Is the moral here not to accept the pronouncement of authorities (including this one!) just because they are authorities? But are most practitioners able to second-guess experts who have spent years and £000s analysing the research? Destructive scepticism throws out the baby with the bathwater, while uncritical acceptance risks accepting mistakes and limited truths as proven and universally applicable facts; in both cases practice and patients could suffer. What is the appropriate stance?

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